Reset form

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Informed Consent for Telemedicine Services

I hereby consent to engaging in telemedicine with Dr. Orna Izakson of Celilo Natural Health Center ("Provider"). I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telemedicine also involves the communication of my medical information, both orally and visually, to health care practitioners.

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.

2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.

3. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.

4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My Provider has explained the alternatives to my satisfaction.

5. I understand that it is my duty to inform my Provider of electronic interactions regarding my care that I may have with other healthcare providers.

6. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that there are potential risks and benefits associated with any form of medical treatment, and that despite the efforts of my Provider, my condition may not improve, in some cases may even get worse, and that no results can be guaranteed or assured.

I understand that there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my Provider, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s); Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment; In rare cases, a lack of access to

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complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

In addition, I understand that telemedicine based services and care may not be as complete as face-to-face services. I also understand that if my Provider believes I would be better served by another form of medical services (e.g. face-to-face services) I will be referred to a medical services provider who can provide such services in my area.

I HAVE NO OTHER PRE-EXISTING MEDICAL CONDITIONS THAT HAVE NOT ALREADY BEEN DISCLOSED TO MY PROVIDER. I understand that this visit/encounter does not and should not replace a traditional doctor's office visit; and therefore, I am proceeding with this tele-evaluation at my own risk and understanding. I also understand that should my condition or my responsible party's be an emergency, I should contact local emergency response by dialing 911. I understand that omitting medical information or misinforming a Provider may result in an inaccurate diagnosis or treatment.

An insurance medical-benefit plan may subject coverage of a telemedical health service to all terms and conditions of the plan, including but not limited to deductible, copayment or coinsurance requirements that are applicable to coverage of a comparable health service when provided in-person.

Governing Law: This Consent, and all claims or causes of action (whether in contract, tort or statute) that may be based upon, arise out of or relate to the provision of telemedicine services as provided for herein shall be governed by, and enforced in accordance with, the internal laws of the State of Oregon.

I have read and understand the information provided above. I have discussed it with my Provider, and all of my questions have been answered to my satisfaction.

I, _____ (*print name*), residing in the State of _____, have read, understood, and agree to the terms entailed above and wish to receive telemedicine services from Dr. Orna Izakson (Celilo Natural Healther Center.)

Signature _____ Date _____